HFS Prior Approval Information Form for Biologic Modifier agents
http://www.hfs.illinois.gov/pharmacy/guidelines.html

A. PHYSICIAN INFORMATION — ALL Information Requested On This Form Must Be Complete

Physician Name: _____ DEA #: _____ License #: _____

Prescriber is a Rheumatologist?	YES	NO

(If NO, list specialty) _____ Office phone #: _____

B. PATIENT INFORMATION

Patient Name:_____ DOB_____/_____/_____ **Patient 9 digit IDPA Recipient Number:**_____

C. PATIENT INFORMATION - DIAGNOSIS and THERAPY INFORMATION

Diagnosis : _____ **Current Patient Weight:** _____

Please complete the following EVEN WITH RENEWAL REQUEST	YES	NO
Failure of at least two forms of DMARD therapy (if no, explain in comment section)		
Positive PPD prior to initiating biologic agent therapy		
History or pre-existing neurological diseases (incl. demyelinating disorders)		
Lupus erythematosus or lupus-like syndrome		
History of malignancy		
Evidence or history of heart failure		
Evidence of infection		
Patient is educated on the administration of the medication (e.g., injection techniques)		
Associated risks and monitoring for side effects (e.g., signs of infection) explained		
Is this a change in agent or dose? If yes, explain in Section E		

REQUESTED DOSE/NDC

- ☐ **Enbrel 25mg: 58406042534 twice weekly**
- ☐ **Enbrel 50mg: 58406043501 twice weekly**
- ☐ **Humira 40mg: 00074379902 every other wk**
- ☐ **Remicade 100mg: 57894003001 Dose = _____**
- ☐ **Orencia 250 mg: 00003218710 Dose = _____**

D. DRUG ACQUISITION and ADMINISTRATION INFORMATION

	YES	NO
Medication will be dispensed to patient by retail pharmacy		
Medication will be dispensed to Long-Term Care (LTC) facility by LTC pharmacy		

Pharmacy name: _____

Pharmacy phone #: _____

E. ADDITIONAL INFORMATION

IMPORTANT: To prevent delay, fax relevant patient information with this form to validate request, or list comments below

COMPLETE ALL INFORMATION TO INSURE PROMPT PROCESSING
Revised 06/02/2006

FAX TO: 217-524-7264
ATTN: MEDICAL COMMITTEE

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F. PHYSICIAN or DESIGNEE'S SIGNATURE: _____ **Date:**_____

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